

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN8205	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/31/2014
NAME OF PROVIDER OR SUPPLIER INDIAN PATH MEDICAL CENTER TRANSITION,		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 BROOKSIDE DRIVE KINGSPORT, TN 37660			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 002	1200-8-6 No Deficiencies During the Life Safety portion of the annual Licensure survey conducted on March 31, 2014, no deficiencies were cited under 1200-8-6, Standards for Nursing Homes.	N 002			

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

VP/CEO

TITLE

(X6) DATE

4/23/14

STATE FORM

6899

5WQL21

If continuation sheet 1 of 1